

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID
Post Payment Safeguards**



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Inspector General**

**JULY 2000
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EXECUTIVE SUMMARY

PURPOSE

This is the last of three reports describing Medicaid program safeguards. This report discusses post payment safeguards. The first report discusses proactive safeguards and the second describes claim processing safeguards. This report is intended to provide information about and increase awareness of Medicaid post payment safeguards. Post payment safeguards ensure that claims have been properly processed and adjudicated.

POST PAYMENT SAFEGUARDS

Remittance Notices furnish providers with information about services billed to Medicaid using their name and provider number. Medicaid providers are asked to report any discrepancies. Unfortunately, remittance notices are sometimes diverted to billing companies or persons unknown to the provider.

Explanation of Benefits are sent to select Medicaid patients. They provide patients with information about providers who billed Medicaid for services provided to them. Patients are asked to verify that they have used or received the services billed to Medicaid.

Post Payment Reviews/Audits and Sampling are used to measure claim payment accuracy, identify incorrectly paid claims, identify problematic policies and procedures and provide feedback on the effectiveness of proactive and claims processing safeguards.

Allegations of Fraud and Abuse are handled differently by each State we visited.

Information is not uniformly captured; therefore, comparing data on Medicaid fraud and abuse efforts is difficult.

Payment Error Rates are used by some States to identify policy vulnerabilities and claims processing vulnerabilities.

OPPORTUNITIES FOR IMPROVEMENT

Based on our prior studies and information gathered during this study, we encourage States to consider the following opportunities for improving program safeguards:

- ▶ **Improve provider remittance notice procedures.** Current procedures do not always ensure that providers receive remittance notices. Some States believe that some remittance notices are diverted to third parties and never seen by the provider whose billing number was used to generate the claim.
- ▶ **Improve provider education.** Every provider should understand that they will be held financially (and, in some cases, criminally and civilly) liable for any Medicaid program financial losses stemming from misuse of their provider number.

- ▶ **Use valid sampling techniques to improve post payment audits.** Using valid sampling enables States to accurately project the total payment error and overpayments made to a provider.
- ▶ **Ensure that some providers selected for post payment review are chosen at random.** Random selection can have a deterrent effect on fraudulent and abusive billing and enables States to identify problematic providers who have circumvented their program safeguards.
- ▶ **Document educational contacts stemming from post payment audits.** Recording education contacts helps establish that a provider have been made aware of unacceptable billing practices.
- ▶ **Improve their surveillance of providers found to have billing problems.** States should verify that a provider has corrected unacceptable billing practices and has not simply found a way to circumvent Medicaid safeguards.
- ▶ **Work with Health Care Financing Administration (HCFA) to establish uniform definitions for audits, edits, reviews, claim counts, rejects, etc..** Clarifying these terms should allow the States and HCFA to compare and contrast efforts in safeguarding Medicaid.
- ▶ **Improve the handling of fraud and abuse allegations.** Their should be written procedures for uniform handling of suspected fraud and abuse situations identified by Medicaid employees and subcontractor employees.
- ▶ **Develop training to help their employees and subcontractors identify potential fraud and abuse issues.** Training would help ensure proper disposition and handling of allegations and help ensure proper referral of cases for in depth investigation.
- ▶ **Collect better data on payment error rates.** Error rate data can be used to identify and address problematic providers, poor policies and vulnerable procedures.

We intend to do additional in depth studies on post payment safeguards used by States.

AGENCY COMMENTS

The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs.

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INTRODUCTION

PURPOSE

To provide information about and increase awareness of Medicaid post payment safeguards.

BACKGROUND

Medicaid is a health insurance program for certain low income and needy people. Within Federal limits, each State decides eligibility, benefit coverage, administrative practices, reimbursement and operational resource requirements. About 70 cents of every Medicaid dollar goes to institutional providers (hospitals, nursing homes). Thirty cents pays for non-institutional services (physician services, laboratory and radiology). Federal law requires States to pay for services provided by certain institutional providers and non-institutional providers. State may elect to offer additional services such as dental care, podiatry care and prescription drugs just to name a few.

The Health Care Financing Administration (HCFA) is responsible for administering Federal matching funds to the States and for legislation and regulations affecting Title XIX (commonly referred to as the Medicaid program). The HCFA also provides guidelines, technical assistance and periodic assessments of State programs. More than 36 million recipients are enrolled in Medicaid. In 1991, 90 percent of these recipients were enrolled in fee-for-service (FFS) programs. By 1998, the number of recipients in FFS had decreased to 46 percent and enrollment in managed care plans increased to nearly 54 percent. Nearly \$169 billion was spent by the Federal Government and the States on Medicaid benefits in Fiscal Year 1998.

States are required by legislation to make every effort to eliminate waste and illegitimate program expenditures. States are required to develop payment safeguards designed to protect their Medicaid funds from unscrupulous and fraudulent providers.

METHODOLOGY

We visited or interviewed over the telephone State agencies responsible for administering the Medicaid program in the following eight States:

California	Florida	Illinois
Louisiana	Maryland	Oregon
Pennsylvania	Texas	

These States were selected for site visits because they account for nearly half of all Medicaid expenditures. They were also chosen for their geographic location. Our site visits were conducted during the spring of 1999. During our visits, we discussed program safeguards used by each State's Medicaid program. We spoke to State Agency officials and, when appropriate, to State subcontractors.

We did not discuss payment safeguards used by managed care organizations and State pharmacy programs. Our discussions focused on Medicaid fee-for-service program safeguards. We have not attempted to assess the effectiveness of each safeguard.

This report is the last of three reports on Medicaid program safeguards. The first report discusses proactive safeguards, those measures taken to prevent fraud, abuse and waste before a claim is ever submitted for payment. The second discusses pre-payment/claim processing safeguards.

The primary purpose of these reports was to compile a catalog of program safeguards used by State Medicaid programs. Every effort was made to prepare a comprehensive and complete list. Some disagreement as to what constitutes a program safeguard may exist and some safeguards may have been overlooked. Fragmentation of responsibility in many State Medicaid programs often makes it difficult to reach all of the people responsible for Medicaid program safeguards. Consequently, States, their subcontractors and others may have information about other safeguard measures not mentioned in this report.

POST PAYMENT SAFEGUARDS

Unlike other safeguards used by State Medicaid programs, post payment safeguards do not prevent patients from receiving excessive or medically unneeded services and they do not prevent erroneous payments from being made to providers. Often referred to as the pay and then chase method, post payment safeguards examine the accuracy of payments that have already been made to providers. Providers who have been paid incorrectly are notified and asked to refund the identified overpayment(s). Providers with egregious claims activity may be referred for further investigation.

REMITTANCE NOTICES

State Medicaid program policies stipulate that payments can only be made to the actual provider of medical care and services. Medicaid payments are made in the name of the provider and sent to a 'pay-to-address' designated by the provider. Payments can be directed to a billing agency, but the actual payment is made out in the name of the provider.

Remittance notices play a key role in State post payment safeguards. All of the States we visited send remittance notices to providers. Remittance notices furnish providers with information about services billed to Medicaid using their provider number. They provide specific information about patients, services billed, adjudication decisions and payments. Providers, who review their remittance notices, should detect additions, deletions and modifications of claims submitted to Medicaid using their provider number.

Remittance notices, like payments, are often directed to someone other than the provider of care shown on the claim submitted for Medicaid reimbursement. Several States told us that they have found cases where providers never saw the payments and remittance notices ostensibly issued to them. Medicaid payments and remittance notices have been diverted to billing companies or addresses unknown to the provider whose billing number was used to generate claims.

State Medicaid programs cannot identify billing agents and the providers who use their services. Seven of the eight States in our sample do not contact providers to verify that they have actually authorized a billing agent/agency, clinic or other health provider to submit claims to Medicaid on their behalf. Florida surveyed physicians and asked them to verify their clinic affiliations. Analysis of the responses resulted in the termination of more than 100 clinics and physicians for irregular billing practices and projected savings of at least \$15 million.

EXPLANATION OF BENEFITS

Another post payment safeguard used by States is the Explanation of Benefits (EOBs). Unlike remittance notices, EOBs are sent to select Medicaid patients rather than to providers. The EOBs provide patients with information about providers who billed Medicaid for services ostensibly provided to them. Medicaid EOBs identify providers and provide information about the nature of services that were billed to Medicaid. Medicaid patients are asked to verify that they have used the services of the provider and received the services billed to Medicaid. Pennsylvania and Illinois follow up on all undeliverable EOBs to determine why they were returned.

Not all Medicaid patients receive EOBs. States are only required to send EOBs to a random sample of patients. Some States target patients who received specific services (e.g., electrocardiograms, x-rays) or received services from a particular type of provider (e.g., podiatrist, dentist). Other States send EOBs to all recipients when targeting specific services or providers. In all cases, patients are asked to review the EOBs and notify the State Medicaid program of any discrepancies.

Several States felt that EOBs were not an effective program safeguard. States mentioned that patients often turn to providers if they have any questions or concerns about the items on their EOB. They also mentioned that many patients cannot read or understand the EOB and that the overall response rate is low. Nonetheless, all eight States in our sample conduct reviews to determine if a potential problem exists whenever a patient notifies them of a suspected billing discrepancy.

POST PAYMENT REVIEWS/AUDITS

State Medicaid programs are required to conduct post payment reviews. In a perfect system, findings from post payment reviews would help State Medicaid programs:

- ▶ measure claim payment accuracy,
- ▶ identify incorrectly paid claims,
- ▶ identify problematic policies and procedures,
- ▶ identify providers who defraud or abuse the system,
- ▶ respond to problem areas and to formulate new policies quickly,
- ▶ provide feedback on the effectiveness of safeguards in the claims processing system, and,
- ▶ provide feedback to those persons responsible for proactive safeguards.

States use post payment audits to identify problematic providers. If problems are confined to a small number of providers, many Medicaid programs flag the provider and place them on prepayment review. If the problems are wide spread, Illinois and Louisiana believe that redesigning program policies and procedures is more cost effective than monitoring each provider.

While States use different criteria for selecting providers for post payment review, most select providers whose practice differs substantially from that of their peers. These “outliers” have been the primary focus of most State post payment efforts. Most States compare providers by specialty and location. They review data on use of specific diagnostic codes, procedures, numbers of patients, prescriptions and other criteria when deciding which providers to review. Florida, Illinois, Louisiana and Texas also review providers whose practice patterns are near the norm for their peer group.

All of the States we visited rely on their Survey and Utilization Review Subsystem (S/URs) to target some, or all, providers for post payment audit.¹ The S/URs is an integral part of each States Medicaid safeguards. Some States claim that the parameters built into S/URs are not easily changed and the system is only capable of producing standardized reports and, in itself, does not provide adequate tools to address today’s sophisticated fraud and abuse schemes. Despite such feelings about S/URs, six of the States we visited do not appear ready to change to neuro networks and other detection systems.

Some States have downloaded claim information to personal computers. They are using personal computer based S/URs to do ad hoc queries to refine and enhance their ability to identify providers and areas for more in-depth post payment study. Some States have enhanced their personal computer capabilities by combining S/URs with decision support systems. These programs allow States more flexibility in analyzing claim data. This in turn helps them to better focus their post payment reviews.

Each State Medicaid program conducts their post payment reviews/audits differently. Some States only audit 10 claims per provider, some focus on specific procedures billed to Medicaid, others use random sampling to produce results that can be projected to the universe and a few sample all claims, or target certain procedures for review.

Onsite visits to providers selected for post payment review/audit are rare. Most requests for needed audit information are handled by mail. In most States, onsite visits to providers are made only when the State determines that a serious problem may exist. When States do make onsite visits, they often notify the provider in advance as to which patient records they will review during their visit.

Of our eight States, Louisiana is the only one that routinely makes unannounced visits to providers selected for post payment review. During the onsite visit they obtain medical records and other documentation needed to determine whether the claim was paid correctly. Louisiana conducts nearly all of its post payment reviews by going onsite to

¹ The S/URs is a sub component of the Medicaid Management Information System (MMIS). The S/URs examines paid claims and produces pre-formatted management reports that identify billing patterns which may be problematic.

review and copy patient records. Providers are not notified as to which records will be reviewed. Louisiana believes that their onsite visits help them to identify bogus providers and deters providers from creating or modifying records required for post payment reviews.

Post Payment Sampling Methodology

Three States we visited do not use sampling methods to select claims for post payment review/audit. These States claim that projections based on sampling do not hold up to court challenges. Consequently, these States do not extrapolate the results of their post payment audits to the universe of claims. Providers are only asked to repay Medicaid the specific amounts identified during post payment review as incorrectly paid. This often results in a mere slap on the wrist because the number of claims reviewed during a post payment audit can be very small involving as few as 10 claims.

Five of our States use random sampling techniques to project overpayments to the universe of claims submitted. Some select a random sample of claims, and others use a random sample of patients seen by a specific provider. Others select a sample of specific procedure codes, diagnostic codes, etc. These States follow accepted sampling techniques and believe that legal challenges to their projects based on sampling will be upheld by the courts.

Provider Education

An integral part of the post payment review process involves provider notification as to the results of the post payment review. State notices to providers contain information about the outcome of the Medicaid audit, identify incorrectly paid services and provide information about the underlying laws, regulations and policies that govern payment. States also advise providers of expected changes in their Medicaid billings that would ensure future compliance.

All of the States we visited make educational contacts with providers whose claims were found to have been incorrectly paid. States conduct their educational contacts at the provider's office, over the telephone or through the mail. Six of the States we visited claim that they document the content of their educational contacts by sending a letter to the provider. Of the eight States, only Maryland mentioned that they save educational contact letters in the provider's file. They use these letters to establish that providers were contacted about unacceptable billing practices and that they were given information on how to correct their aberrant billing.

Saving educational contact letters in the provider's file enables Medicaid to determine how often they have asked the provider to correct their billing practices. They are also useful in showing that a provider knew the law, regulations and policies but changed their behavior to avoid detection. A State Medicaid program may need to use this documentation of provider contacts to justify a referral for criminal or civil investigation or administrative removal of the provider from their program.

Verification of Compliance

Three of the eight States we visited, verify that providers have changed their billing behavior following notification that their past billing practices were unacceptable. Some States simply examine information about the number of claims that edit for the specific problem. Others not only examine edit counts but also conduct another claim audit to ensure that the past problems have been corrected and to ensure that the provider has not simply changed their billing to avoid detection.

ALLEGATIONS OF FRAUD AND ABUSE

States receive allegations of fraud and abuse from a number of internal and external sources. Each of the States in our sample handles these allegations differently. One State only records cases accepted for further investigation by its internal program integrity unit. Consequently, the State has no records that would indicate the total fraud and abuse workload addressed by its employees. States that do keep records on all allegations appear to be in a better position to identify providers with multiple allegations. These States are also in a better position to measure their fraud and abuse workload and the disposition of that workload.

Processes used to control and resolve allegations of fraud and abuse appear weak. Some States have not done a good job in educating their employees concerning fraud and abuse and the procedures for handling such complaints. States appear to be out of the loop when it comes to fraud and abuse training and establishing criteria to ensure proper handling of such allegations. At the 1999 National Health Care Anti-fraud and Abuse conference, only 10 States sent representatives. Most State attendees were from State agencies other than Medicaid. Only three States sent Medicaid personnel to the conference to learn about emerging fraud schemes and safeguards to protect their programs from such schemes.

PAYMENT ERROR RATES

Payment error rates include anything from inadvertent mistakes to outright fraud. We know of no studies that have quantified what portion of the payment error rate is attributable to fraud. Some States have, however, estimated provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded or non-covered. The prevalence of fraud in the State Medicaid programs remains unknown.

Three of the eight States we contacted had attempted to determine their Medicaid payment error rate. All used a State Agency, independent of the Medicaid program, to estimate the overall claim payment error rate. Initial estimates of payment error ran up to 15 percent, considerably higher than final estimates which fell in the 3 to 5 percent range.

States that have attempted to quantify their payment error rate do so by selecting a weighted sample using provider type and claims volume. Their sample was drawn from the universe of fee-for-service providers and does not include managed care claims, pharmaceutical claims or long-term care claims.

The remaining States have not conducted an independent audit of their Medicaid claims to determine payment accuracy. They rely on post payment audits conducted by their claims processing department, program integrity unit or subcontractor to determine payment error rates. In one State, the State comptroller uses statistical samples to determine whether providers (pharmacies, managed care organizations and long-term care facilities) have been correctly paid. The comptroller does not assess the medical necessity of services provided but merely determines whether safeguards in the system work as intended.

OPPORTUNITIES FOR IMPROVEMENT

Post payment safeguards examine the accuracy of claims that have already been processed. These safeguards have a sentinel effect and help deter provider fraud and abuse. Comparing data may result in an inaccurate picture of a State's efforts to decrease claim payment errors and to prevent fraud and abuse. Based on information obtained from this inspection and past studies, we encourage States to:

Improve their provider remittance notice procedures.

Some States believe that some remittance notices are diverted to third parties and never seen by the provider whose billing number was used to generate the claim. Current policies and procedures do not ensure that the provider will actually receive a remittance notice. Providers, who do receive them, may not review them for accuracy. The Florida Medicaid Agency's effort to verify physician practice address(es) and clinic affiliations uncovered provider number misuse, fraud and abuse. Other States should consider a similar project not only to detect fraud and abuse but also to underscore provider responsibility to protect their billing number(s) and to review remittance notices.²

Improve provider education.

Every provider should understand that they will be held financially (and, in some cases, criminally and civilly) liable for any Medicaid program financial losses stemming from misuse of their provider.³

Improve post payment audits.

Selecting 10 claims for post payment review from a provider's entire billing history may be a vulnerability. States need to be aware that a problem found more than one claim when using very small sample sizes may indicate a more extensive problem and not simply random error. States that find one or more problems in a small sample should expand their reviews and focus on the problem area(s).

² For more information see *Medical Billing Software and Processes Used to Prepare Claims*. OEI-05-99-00100

³ Ibid.

Use valid sampling techniques.

States that claim barriers exist to their use of random sampling should discuss those barriers with HCFA and other States. Moreover, States might want to consider conducting a small probe sample before investing resources in a larger statistically valid sample that can be used to project overpayments.

Ensure that some providers selected for post payment review are chosen at random.

More emphasis should be placed on random selection and less focus on providers whose practice exceeds that of their peers. States should examine providers near their peer norm. They should also review providers with little or no billing to determine if they are still a legitimate Medicaid provider. Random selection can have a deterrent effect on fraudulent and abusive billing and enables States to identify problematic providers who have circumvented their program safeguards.

Document educational contacts stemming from post payment audits.

Problems found during claim reviews should be discussed directly with the provider either in person or over the telephone. These conversations should be memorialized in a certified letter to the provider and a copy maintained in a specific State file. This demonstrates that the provider was made aware of the problem(s) should additional action be required.⁴

Improve their surveillance of providers found to have billing problems.

States could conduct another audit to ensure that the provider corrected the unacceptable billing practices identified in the initial post payment audit. These follow up reviews/audits could be used to ensure that the provider has indeed changed his billing practices and has not found a way to circumvent Medicaid safeguards.

Work with HCFA to establish uniform definitions for audits, edits, reviews, claim counts, rejects, etc.

Clarifying these terms should allow the States and HCFA to compare and contrast efforts in safeguarding Medicaid.

⁴ Additional information can be found in our report entitled, Carrier Fraud Units. OEI-05-94-00470.

Improve the handling of fraud and abuse allegations.

There should be written procedures for handling suspected fraud and abuse identified by Medicaid employees and subcontractor employees. A single point within the State Medicaid program should be responsible for addressing fraud and abuse concerns raised by State Agency employees and their subcontractors.

Develop training to help their employees and subcontractors identify potential fraud and abuse issues.

Employees should be trained to recognize potential fraud and be able to differentiate fraud from abuse.⁵ Training should enable employees to determine if discrepancies on claims are material. Erroneous claim information that does not affect payment probably is not fraud or abuse. On the other hand, erroneous information that results in payment when the true information results in no, or a lower, payment may be significant. Improved training would help ensure proper disposition and handling of allegations and help ensure proper referral of cases for in depth investigation.

Collect better data on payment error rates.

Some States have used payment error rate data to identify and address problematic providers, poor policies and vulnerable procedures. Reliance on subcontractor measures of payment accuracy may be a vulnerability. States should periodically conduct their own measures of payment error. The States should also work with HCFA to establish criteria for classifying payment errors (i.e., medically unnecessary, service billed is greater/less than supported by the medical record, no documentation to support service, etc.).

AGENCY COMMENTS

We received comments on this report from HCFA. The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs. The full text of HCFA's comments can be found in Appendix A.

⁵ Additional information about processing allegations of fraud and abuse can be found in our report entitled, Carrier Fraud Units. OEI-05-94-00470.

APPENDIX A

HCFA Comments on this Report



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN 15 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payment Safeguards: Proactive Safeguards, Claims Processing Safeguards, and Post Payment Safeguards," (OEI-05-99-00070, OEI-05-99-00071, and OEI-05-99-00072)

The Health Care Financing Administration (HCFA) would like to thank the OIG for allowing us the opportunity to review the above-mentioned reports.

Since 1993, the Clinton Administration has done more than any previous administration to fight fraud, waste, and abuse in the Medicare and Medicaid programs. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered more than \$500 million as a result of health care prosecutions.

HCFA has helped fight the battle of Medicaid fraud, waste, and abuse by partnering with States, beneficiaries, providers, contractors, and other federal agencies. The States themselves, are primarily responsible for detecting, prosecuting, and preventing Medicaid fraud, waste, and abuse. HCFA provides funding and technical assistance, and oversees States in their efforts to ensure that taxpayer dollars are spent appropriately. We also provide States with comprehensive guidance and technical support so they can strengthen efforts to prevent improper payments rather than try to recoup them after the fact. HCFA has been working with States to help them develop better data systems and other technological tools for ferreting out fraud, waste, and abuse. We are modifying our National Fraud Investigation Database to include Medicaid cases which will further help in tracking down and stopping unscrupulous providers across the country.

The focus of the National Medicaid Fraud and Abuse Initiative, has been to combat fraud and abuse in partnership with the States. We are also working to help States develop more proactive safeguard measures. The National Initiative was established in June 1997 and we have accomplished many things over the past three (3) years

Specifically, in August, 1997 we conducted a focus group session with States soliciting ideas for preventing fraud and abuse. As a result, we have :

- ◆ Worked with our State partners to develop a Medicaid Fraud and Abuse Control Technical Advisory Group (TAG);
- ◆ Established a Medicaid Fraud Statutes Website which contains a comprehensive database of state program integrity provisions;
- ◆ Developed draft Guidelines for Addressing Fraud and Abuse in Managed Care; and
- ◆ Developed a draft Medicaid Managed Care Compliance Plan which will soon be made available to States.

In our National Medicaid Fraud and Abuse initiative we maximize collaboration and communication among States and Federal Agencies. This involves:

- ◆ Working with your office, the Department of Justice, the Medicaid Fraud Control Units and Program Integrity Units in their role of prosecuting fraudulent providers,
- ◆ Ensuring that all States are aware of fraudulent activities and scams occurring nationwide,
- ◆ Promoting consistency by developing national guidelines;

However, we agree that more needs to be done, and we are committed to repeating and building upon the success across the country. The OIG should be aware that HCFA is exploring the feasibility of measuring Medicaid payment error rates on a State-specific and national basis. The purpose of such an initiative would be to measure and ultimately reduce Medicaid payment errors.

We believe the "Opportunities for Improvements" described in each report provided us with valuable information. As we mentioned at the March 9, 2000 exit conference with the OIG, we applaud the presentation of their suggestions as "opportunities." We believe States will view most of these "opportunities" as constructive and when the OIG releases these three reports in final form, we will ask our regional offices to share them with their States.

